BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: Chander Prakash Sharma, M.D. 16415 Colorado Ave., Suite 304 Paramount, CA 90723 Physician's and Surgeon's Certificate No. A 30135, Respondent.	Case No. 11-97-79951 OAH No. L-1999040592

DECISION

The attached Proposed Decision of the Administrative Law Judge is hereby adopted by the Medical Board of California as its Decision in the above-entitled matter.

This Decision shall become effective February 3, 2000.

IT IS SO ORDERED January 4, 2000.

MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

By _____
Alan E. Shumacher, M.D.
Acting Chair, Panel A
Division of Medical Quality

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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
CHANDER PRAKASH SHARMA, M.D. **16415 Colorado Avenue, Suite 304** **Paramount, California 90723**	)	**Board Case No. 11-97-79951** **OAH No. L-1999040592**
Physician's and Surgeon's Certificate No. A 30135,	)	
Respondent.	)	

PROPOSED DECISION

On September 28, 29 and 30, 1999 and October 1 and 4, 1999, in Los Angeles, California, H. Stuart Waxman, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter.

Complainant, Ron Joseph ("Complainant"), was represented by E.A. Jones III, Deputy Attorney General.

Respondent, Chander Prakash Sharma, M.D. ("Respondent") was present and was represented by John C. Mulvana, Attorney at Law.

Oral and documentary evidence was received. The record was held open until the close of business on November 15, 1999 for the parties to submit post-hearing briefs. Among the issues requested to be briefed was the admissibility of Exhibits B, J, K, L and M.[1] On November 12, 1999, Respondent's counsel requested the record be held open to and including November 19, 1999 for counsel to submit the briefs due to the late arrival of part of the trial transcript. Complainant's counsel joined in that request on November 15, 1999. The request was granted.

[1] The Administrative Law Judge had already ruled on the admissibility of those exhibits. Briefing on those issues was intended for purposes of reconsideration.

The post-hearing briefs were timely received. Complainant's Amended Cost Certification for the Deputy Attorney General was marked and admitted as Complainant's Exhibit 17. Complainant's "Closing Brief" was marked as Complainant's Exhibit 18 for identification. Respondent's "Closing Brief" was marked as Respondent's Exhibit "Y" for identification. Briefing on the admissibility of Exhibits B, J, K, L and M was received from Respondent only. On November 19, 1999, the record was closed and the matter was deemed submitted for decision.

Upon reconsideration, the Administrative Law Judge's rulings on the admissibility of Exhibits B, J, K, L and M remain unchanged.

FACTUAL FINDINGS

The Administrative Law Judge makes the following Factual Findings:

1. Ron Joseph made the Accusation in his official capacity as Executive Director of the Medical Board of California ("the Board").

2. On June 2, 1976, the Board issued Physician and Surgeon Certificate No. A 30135 to Respondent. The license was in full force and effect at all relevant times. It will expire on January 31, 2001 unless renewed.

3. Respondent was born in New Delhi, India. After completing high secondary school in that country, he entered the University of New Delhi as a pre-med student and ranked within the university's top ten students. He graduated from Malmuna Adad Medical College (part of the University of New Delhi) in 1972. After serving an internship in India, he immigrated to the United States. He served a two-year residency in pediatrics at Martin Luther King/UCLA Medical Center in Los Angeles and completed his residency in pediatrics at Los Angeles County/USC Medical Center in Los Angeles. The following year, he served in a fellowship in infectious diseases. Respondent began in private practice in 1978. Since 1983 or 1984, his practice has consisted of approximately 70-75% pediatric patients and 25-30% adult patients. Respondent is married and has three children.

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Quality of Care Issues

4. On April 9, 1993, B.R., a 32-year-old male, presented at Respondent's office for the purpose of refilling his asthma medication, originally prescribed at another medical facility. He filled out a patient history questionnaire. He listed as his "main problems" sinus trouble, asthma, bronchitis, chest pain and shortness of breath while lying down. He did not disclose his history of high blood pressure, kidney problems which had arisen during his adolescence, and recurrent nosebleeds. His family history included diabetes and allergies. His social history included smoking and alcohol use. B.R. listed his current medications as Proventil inhaler, Tussi Organidin, Vanceril inhaler and Vancenase AQ. Respondent spent approximately 35-40 minutes questioning B.R. concerning his medical history. B.R. stated that he was a mechanic who had lost his job, that he was having marital problems and that he and his wife were unable to have children.

5. Respondent then performed a complete physical examination on B.R. (except for a rectal examination). He confirmed the initial blood pressure reading of 158/110 at least twice. He performed a fundoscopic examination which was negative. He found fluid behind the eardrums, middle turbinate hypertrophy and discoloration of the sinus mucous membranes, all findings consistent with allergies. He also noted bilateral ronchi present. There were no symptoms suggestive of congestive heart failure, renal dysfunction, nosebleeds or endocrine problems. Based on B.R.'s history and physical examination, Respondent formed a clinical impression of bronchial asthma, allergic rhinitis, acute pharyngitis with upper respiratory infection, and hypertension. He prescribed Theodur, Proventil tablets, Amoxicillin (for one week), Proventil Inhaler and Vanceril inhaler. He charted a follow-up blood pressure check. He asked B.R. to obtain his medical records from his former physician, Dr. Rose. Nothing in Respondent's history, physical examination, diagnosis or treatment of B.R. indicated a deviation from the standard of care.

6. However, Respondent failed to chart some of the more significant historical data. The history and physical information he did chart was illegible. His failure to make legible entries on his patient's chart constitutes a simple departure from the standard of care.

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7. B.R. returned to Respondent's office on April 13, 1993 complaining of abdominal pain, nausea and shortness of breath. His blood pressure was 170/112. Breath sounds were clear with some ronchi indicating improvement in B.R.'s asthma. B.R. reported experiencing upper abdominal pain after eating hot, spicy, Indian food. He got relief from Mylanta. He stated he had slept poorly the night before because of an argument he had had with his wife. He also stated the episodes of shortness of breath had been less frequent but that he had not been taking the Proventil tablets. Respondent did not note those facts in the patient's chart. The chart entries he did make were illegible. Respondent performed a physical examination on B.R. The examination indicated improvement from the infection. Bowel sounds were normal and there were no masses or distension. He therefore determined the abdominal pain and nausea to be the result of the spicy foods B.R. had eaten. Respondent's clinical impression was bronchial asthma, dyspepsia, bronchitis and hypertension. He prescribed Pepcid for the abdominal pain and told B.R. to continue the Amoxicillin, Theophylline and Proventil. He scheduled a follow-up for one week to do a work-up of B.R.'s hypertension. In so doing, he intended to refer B.R. to Dr. Deveraj, a cardiologist. Respondent's history, examination and treatment of B.R. on April 13, 1993 were within the standard of care. However, his failure to chart pertinent information and his illegible entries in the chart constitute a simple departure from the standard of care.

8. B.R. returned to Respondent's office on April 20, 1993 complaining of a sore throat. In the chart, under "Chief Complaints", Respondent wrote that B.R. had a sore throat and a history of severe asthma. He left the section entitled "Pertinent Problems & History" blank. In filling out the chart as he did, Respondent did not mean that B.R. was complaining of severe asthma on that day. However, although he noted the history of asthma, Respondent did not indicate a history of shortness of breath. B.R.'s blood pressure was 160/100, an improvement from his last visit. B.R. reported that his high blood pressure was stress related and that it was improving as his relationship with his wife improved. Respondent did not make any note in the chart regarding stress-related hypertension. B.R. reported a strong family history of diabetes and asked Respondent to check his cholesterol and blood sugar. Respondent ordered a cardiac profile and urine dipstick to rule out diabetes. The results of the urine dipstick were misplaced and were not placed into the chart until Respondent found them a few years later. However, the cardiac profile was negative for diabetes (as was the result of the urine dipstick). The entries Respondent made into B.R.'s chart on April 20, 1993 were illegible.

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9. B.R. had finished his course of Amoxicillin. Respondent believed B.R.'s respiratory tract problems could then be best treated with a wide spectrum antibiotic. He therefore prescribed Cipro. He continued B.R. on the Theophylline, Pepcid and Proventil. He informed B.R. he might have to see a cardiologist if his blood pressure increased again and told him to continue on the non-drug therapy he had recommended earlier for his hypertension. He asked B.R. about his medical records from Dr. Rose as Respondent had requested earlier. (B.R. never obtained those records). Respondent scheduled another appointment for April 30, 1993.

10. Respondent's history, examination and treatment of B.R. on April 20, 1993 were within the standard of care. However, his failure to chart pertinent information, his inaccurate charting, and his illegible entries in the chart constitute a simple departure from the standard of care.

11. B.R. failed to keep his April 30 appointment but rescheduled for May 3, 1993. At that time, B.R. returned for a follow-up on his blood pressure which was 172/118. Physical signs and symptoms were consistent with allergies and possible infection. B.R. was not in respiratory distress but had occasional expiratory ronchi. Heart signs were normal. Respondent's clinical impression was hyperlipedemia (elevated blood fats according to the April 20 blood test), bronchial asthma and allergic rhinitis. He discussed with B.R. his allergies and asthma and whether it was necessary for him to undergo a pulmonary function test and/or to check Theophylline levels. Respondent made appropriate but illegible notes in B.R.'s chart.

12. Respondent recognized that B.R. was severely hypertensive. Since he was unaware of B.R.'s history of hypertension, he had tried to give B.R. the "benefit of the doubt" that his high blood pressure had been related to stress. However, on May 3, Respondent realized that was not the case. He informed B.R. his hypertension was not stress related and that he had to see the cardiologist. Respondent then telephoned the cardiologist directly. B.R. informed Respondent he was unable to see the cardiologist that day. B.R. then requested that Respondent write a letter on his behalf for an unemployment judge's review. Respondent agreed to do so and told B.R. he could pick up the letter the following day. Respondent did not perform another fundoscopic examination because there would have been no difference from the first examination which Respondent had performed only 24 days earlier.

13. It was Respondent's custom and practice to refer all severely hypertensive patients to Dr. Deveraj for work-up and treatment. However, Respondent recognized that, given B.R.'s blood pressure reading on May 3 and the fact that B.R. was not going to the cardiologist on that day, B.R. was risking serious health consequences which could occur at any time (i.e. heart attack, stroke, renal failure or vision changes). Respondent therefore provided B.R. with samples of Maxide and Isoptin (Vertapamil STZ) as a temporary preventive measure until he could see Dr. Deveraj. He also ordered B.R. to remain on a low cholesterol diet. B.R. was given an appointment to return to Respondent's office in one week.

14. Respondent's history, examination and treatment of B.R. on May 3, 1993 were within the standard of care. However, his illegible entries in the chart constitute a simple departure from the standard of care.

15. B.R. failed to keep his appointment on May 10. He rescheduled for May 17 but failed to keep that appointment as well. When B.R. failed to keep those appointments, Respondent telephoned Dr. Deveraj to ascertain whether Dr. Deveraj had seen B.R. He had not. Respondent then telephoned B.R. and told him how important it was for him to see a cardiologist. B.R. stated he felt fine but that he would make the appointment. Respondent also asked B.R. to make an appointment with him. B.R. said he would do so but not at that time. He subsequently scheduled an appointment with Respondent for June 7, but failed to keep that appointment. Respondent again telephoned B.R. and warned him of the possible complications to his condition. B.R. stated he would make another appointment. Respondent explained to B.R. that he was unable to help him without his cooperation.

16. Respondent did not hear from B.R. again until October 20, 1993, when he appeared at Respondent's office without an appointment demanding to be seen for the purpose of obtaining a refill of his asthma medication. Respondent agreed to see him. B.R.'s blood pressure was 180/120. Breath sounds were clear with occasional ronchi. There was no shortness of breath. Heart sounds and abdomen were normal. However, B.R. had not taken his medications for five months. Respondent diagnosed him as suffering from uncontrolled hypertension and hyperlipedemia. He told B.R. he was "sitting on a time bomb" and that his first priority was to immediately lower his blood pressure and to look for its causes later. He gave B.R. the options of going to Dr. Deveraj or to an emergency room. B.R. did not accept either option. Realizing that B.R. could suffer a stroke at any time but nonetheless refused to get help, Respondent found himself in a dilemma. He chose to give B.R. samples of Zocor and Lotensin to reduce his blood pressure. He also resumed the Verapamil STZ and the inhalers. He did not schedule a follow-up appointment because he believed he could do no more for his non-compliant patient. Respondent made appropriate notations in B.R.'s chart. However, the notations are illegible.

17. At that point, Respondent's failure to either perform the requisite tests to properly evaluate B.R.'s hypertension, continue his attempts to get B.R. to accept a referral to a cardiologist, or to notify B.R. that his hypertension still required evaluation but that Respondent was terminating his attempts in that regard, constitutes a simple departure from the standard of care. It is not deemed an extreme departure in this case since B.R. had not seen Respondent for several months, had not complied with Respondent's treatment plan, and had not consulted with the cardiologist. Therefore, it was not unreasonable for Respondent to believe that any further attempts would be futile. Respondent's illegible entries in the chart constitute a separate simple departure from the standard of care.

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18. In November of 1993, B.R. suffered renal failure and was placed on dialysis. He was diagnosed with glomerulonephritis, a chronic condition the cause of which was unrelated to his hypertension. Complainant suggests that Respondent's providing Lotensin to B.R. may have contributed to the renal failure. It is highly probable that the Lotensin was not related to the renal failure. B.R. admitted he took only one unidentified antihypertensive tablet.

19. The parties' experts disagree as to whether Respondent met the standard of care in all respects. Complainant's expert contends Respondent failed to obtain an adequate history and failed to do an adequate work-up. He opined Respondent should not have prescribed Zocor without first having the patient undergo a liver function test. He criticized Respondent's methods, both with respect to his clinical skills and procedures, and with respect to his record keeping which he believes to have been incomplete, inadequate and illegible. He found Respondent had committed extreme departures from the standard of care, and had also committed several simple departures from the standard of care which, in the aggregate, constituted an extreme departure. However, Complainant's expert softened his position considerably on cross-examination, admitting that he did not read or consider certain available evidence indicating that Respondent complied with the standard of care, admitting it was not a deviation from the standard of care to refer a patient such as B.R. to a cardiologist, and admitting that the failure of a patient to follow through on a referral is not the responsibility of the treating physician.

20. Respondent's expert believes Respondent satisfied the standard with respect to his evaluation, diagnosis and treatment of B.R. He further believes Respondent was justified in referring B.R. to the cardiologist and was not obligated to do the work of the cardiologist when B.R. refused to make an appointment. He does not believe it was necessary to perform a liver function test before prescribing Zocor since, absent a history of liver disease, that test is not indicated until the patient has been taking the medication for 4-6 weeks. However, Respondent's expert was silent with respect to the need for a physician's charts to be legible.

21. Respondent saw B.R. four times over a period of only 24 days, and then one last time several months later. B.R. had not disclosed significant portions of his medical history which would have alerted Respondent to the possible necessity of more aggressive testing and treatment. Further, Respondent was unaware, until the fourth visit on May 3, 1993, that B. R. had not been compliant with his treatment plan. It was not until after that date that Respondent became aware that B.R. had not been seen, and probably planned not to be seen, by Dr. Deveraj. By that time, even if Respondent immediately chose to undertake a full cardiac work-up, he could not have done so because B.R. did not return to Respondent's office until October of that year.

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22. However, Respondent did know, within the first few weeks of seeing B.R., that B.R. suffered from chronic hypertension. Respondent took immediate steps to have the condition evaluated and treated. B.R.'s failure to obtain the necessary testing and treatment was due to B.R.'s own non-compliance and not a failure of Respondent to act.

Trespass Conviction

23. On November 17, 1997, in Orange County Municipal Court, in Case No. AN97NM05632, Respondent was convicted, on his plea of guilty, of violation of Penal Code section 602(J) (Trespass: Injury to Property), a crime inherently involving moral turpitude and one substantially related to the qualifications, functions and duties of a Medical Board licensee.

24. Respondent was placed on informal probation for a period of three years under various terms and conditions including payment of fines and restitution totaling $920.00 and an agreement to stay out of Fry's Electronics in Orange County.

25. The facts and circumstances underlying the conviction arose out of a dispute between Respondent and personnel in Fry's Electronics. Respondent purchased a computer printer at the store but the printer failed to function properly. He returned it for repair but, after waiting a full year, had not received it back in operating condition. On the day of the incident, Respondent went to the store to check on the status of the repair and to return an inoperative software program. After waiting 15-20 minutes for service, he was told he could not return the software program because of the store's no-return policy on software. He then went to check on the printer and was told "You Indians are all like this." He was told the printer only needed soldering. Respondent was angry at the salesperson for treating him so rudely. He told the salesperson he would pick up a soldering iron and repair the printer himself. He then shoplifted a soldering iron and some solder. He was apprehended upon leaving the store.

26. Respondent is extremely remorseful for his lapse in judgment. He has complied with all of the terms of his probation. On his own volition, he took steps to ensure nothing similar would ever recur by seeking counseling from his spiritual teacher. Beginning in March of 1997, he attended two 1½-hour sessions per week for two months (a total of 16 sessions). He believes the counseling has helped him tremendously. He has had no further outbursts of anger. Probation is scheduled to terminate in November of 2000.

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Costs

27. Pursuant to Business and Professions Code section 125.3, Complainant's counsel requested that Respondent be ordered to pay to the Board $26,515.90 for its costs of investigation and prosecution of the case. The costs consist of $7139.20 for investigative services, $8676.70 for expert witness fees, and $10,700.00 in Attorney General's fees. Complainant sustained his burden of proof on only some of the allegations, and is therefore not entitled to all of the requested costs and fees. However, the costs and fees are not broken down according to which ones were incurred in connection with the specific issues referenced in the Accusation. While there is no statutory or regulatory requirement that they be broken down in that manner, absent such a division, the reasonableness of the cost bill is determined using a percentage of the costs, based upon the number and complexity of the proven issues.

28. In the Accusation, Complainant alleged that Respondent was grossly negligent, was guilty of repeated negligent acts, and was incompetent, both with respect to his care and treatment of B.R., and in his record keeping. Since the facts were the same with respect to each of the three causes for discipline, presumably approximately the same time and effort went into proving each of those three causes for discipline. Thus, Complainant should recover his costs for each issue proven even if he prevailed on only one cause for discipline. In this case, he proved Respondent committed repeated negligent acts with respect to his record keeping. However, Complainant did not prevail on the issue of B.R.'s care and treatment with respect to any of the three causes for discipline. In addition to the record keeping issue, Complainant prevailed on the causes for discipline relating to Dishonesty or Corruption and Conviction of an Offense. Although Complainant prevailed on most of the issues, the issue of B.R.'s care and treatment was the most complex of the issues presented. Accordingly, Complainant's failure to sustain his burden of proof on that issue must result in a substantial reduction in awarded costs, particularly in light of the fact that his expert witness apparently was not involved in the investigation and prosecution of the Dishonesty/Corruption and Conviction issues. On that basis, the Administrative Law Judge deems $15,376.78, a sum approximately equivalent to 70% of the investigative services and Attorney General's fees, and 33.3% of the expert witness's fees, to be the reasonable amount of costs recoverable in this case.

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LEGAL CONCLUSIONS

Pursuant to the foregoing Factual Findings, the Administrative Law Judge makes the following legal conclusions:

1. Cause does not exist to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234(a) and (b), for gross negligence, as set forth in Findings 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21 and 22.

The standard of proof to be used in these proceedings is "clear and convincing." (Ettinger v. Board of Medical Quality Assurance (1982) 135 Cal.App.3d 853, 856, 185 Cal.Rptr. 601.) This means the burden rests on Complainant to establish the charging allegations by proof that is clear, explicit and unequivocal--so clear as to leave no substantial doubt, and sufficiently strong to command the unhesitating assent of every reasonable mind. (In re Marriage of Weaver (1990) 224 Cal.App.3d 478.) Complainant failed to meet that standard as to his allegations of gross negligence.

2. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234(a) and (c), for repeated negligent acts with respect to his record keeping, as set forth in Findings 6, 7, 8, 10, 14, 16, and 17, 19 and 20.

3. Cause does not exist to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234(a) and (c), for repeated negligent acts with respect to his care and treatment of patient B.R., as set forth in Findings 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21 and 22. Only one act of simple negligence was found in connection with that issue.

4. Cause does not exist to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234(a) and (d), for incompetence, as set forth in Findings 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21 and 22.

5. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code sections 2227 and 2234(a) and (e), for dishonesty or corruption, as set forth in Findings 23, 24 and 25.

6. Cause exists to revoke or suspend Respondent's certificate, pursuant to Business and Professions Code sections 2227, 2234(a) and 2236, for conviction of an offense, as set forth in Findings 23, 24 and 25.

7. Cause exists to order Respondent to pay the costs claimed under Business and Professions Code section 125.3, as set forth in Finding 27 and 28.

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This matter represents the only disciplinary action taken against Respondent in the 23 years he has held a medical certificate in this State. The evidence demonstrated him to be an otherwise experienced and skilled physician.

The purpose of an administrative disciplinary proceeding such as this one is to protect the public interest, rather than to punish the licensee. Camacho v. Youde (1979) 95 Cal.App.3d 161, 164. Discipline is unquestionably warranted in this case. However, the public will be better served by improving Respondent's knowledge, skills and ethics than by permanently depriving him of his license to practice. Therefore, it will not be contrary to the public interest for Respondent to be granted a properly conditioned probationary license.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Certificate No. A-30135 issued to Respondent, Chander Prakash Sharma, M.D., is revoked. However, the revocation is stayed and Respondent is placed on probation for five years upon the following terms and conditions. Within 15 days after the effective date of this decision, Respondent shall provide the Division, or its designee, proof of service that Respondent has served a true copy of this decision on the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent or where Respondent is employed to practice medicine and on the Chief Executive Officer at every insurance carrier where malpractice insurance coverage is extended to Respondent.

1. Within 60 days of the effective date of this decision, Respondent shall enroll in a course in Ethics approved in advance by the Division or its designee, and shall successfully complete the course during the first year of probation.

2. Within 90 days of the effective date of this decision, Respondent shall submit to the Division or its designee for prior approval, a clinical training or educational program. The exact number of hours and specific content of the program shall be determined by the Division or its designee. Respondent shall successfully complete the training program and may be required to pass an examination administered by the Division or its designee related to the program's contents.

3. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

4. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Division, stating whether there has been compliance with all the conditions of probation.

5. Respondent shall comply with the Division's probation surveillance program. Respondent shall, at all times, keep the Division informed of his addresses of business and residence which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Division. Under no circumstances shall a post office box serve as an address of record.

Respondent shall also immediately inform the Division, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) days.

6. Respondent shall appear in person for interviews with the Division, its designee or its designated physician(s) upon request at various intervals and with reasonable notice.

7. In the event Respondent should leave California to reside or to practice outside the State or for any reason should Respondent stop practicing medicine in California, Respondent shall notify the Division or its designee in writing within ten days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty days in which Respondent is not engaging in any activities defined in Sections 2051 and 2052 of the Business and Professions Code. All time spent in an intensive training program approved by the Division or its designee shall be considered as time spent in the practice of medicine. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary period.

8. Upon successful completion of probation, Respondent's certificate shall be fully restored.

9. If Respondent violates probation in any respect, the Division, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against Respondent during probation, the Division shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

10. Respondent is hereby ordered to reimburse the Division the amount of $15,376.78 within 90 days from the effective date of this decision for its investigative and prosecution costs. Failure to reimburse the Division's cost of its investigation and prosecution shall constitute a violation of the probation order, unless the Division agrees in writing to payment by an installment plan because of financial hardship. The filing of bankruptcy by Respondent shall not relieve Respondent of his responsibility to reimburse the Division for its investigative and prosecution costs.

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11. Respondent shall pay the costs associated with probation monitoring each and every year of probation. Such costs shall be payable to the Medical Board of California at the end of each fiscal year. Failure to pay such costs shall be considered a violation of probation.

12. Following the effective date of this decision, if Respondent ceases practicing due to retirement, health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may voluntarily tender his certificate to the Board. The Division reserves the right to evaluate Respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, Respondent will no longer be subject to the terms and conditions of probation.

DATED: December 15, 1999

H. STUART WAXMAN
Administrative Law Judge
Office of Administrative Hearings

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BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the **Accusation** Against: **CHANDER PRAKASH SHARMA, M.D.** 16415 Colorado Avenue, Suite 304 Paramount, California 90723 Physician's and Surgeon's Certificate No. A 30135, Respondent.	Case No. 11-97-79951 **A C C U S A T I O N**

The Complainant alleges:

PARTIES

1. Ron Joseph ("Complainant") brings this Accusation solely in his official capacity as the Executive Director of the Medical Board of California (hereinafter the "Board").

2. On or about June 2, 1976, Physician's and Surgeon's Certificate No. A 30135 was issued by the Board to Chander Prakash Sharma, M.D. (hereinafter "respondent"). At all times relevant to the charges brought herein, this license has been in full force and effect. Unless renewed, it will expire on January 31, 2001. Respondent is not currently approved as a supervisor of a physician assistant.

JURISDICTION

3. This Accusation is brought before the Division of Medical Quality of the Board (hereinafter the "Division"), under the authority of the following sections of the Business and Professions Code (hereinafter "Code"):

A. Section 2227 of the Code provides that the Division may revoke, suspend for a period not to exceed one year, or place on probation and order the payment of probation monitoring costs, the license of any licensee who has been found guilty under the Medical Practice Act.

B. Section 2234 of the Code provides that unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter.

"(b) Gross negligence.

"(c) Repeated negligent acts.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"...."

C. Section 2236 of the Code provides, as relevant hereto, that the conviction of any offense substantially related to the qualifications, functions, or duties of a physician and surgeon constitutes unprofessional conduct within the meaning of this chapter. A plea or verdict of guilty or a conviction after a plea of nolo contendere is deemed to be a conviction within the meaning of this section. The record of conviction shall be conclusive evidence of the fact that the conviction occurred.

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D. Section 125.3 of the Code provides, as relevant hereto, that the Board may request the administrative law judge to direct any licentiate found to have committed a violation or violations of the licensing act, to pay the Board a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

4. Section 14124.12 of the Welfare and Institutions Code provides, as relevant hereto, that upon receipt of written notice from the Board that a licensee's license has been placed on probation as a result of a disciplinary action, the Department of Health Services (department) of the State of California may not reimburse any Medi-Cal claim for the type of surgical service or invasive procedure that gave rise to the probation that was performed by the licensee on or after the effective date of probation and until the termination of all probationary terms and conditions or until the probationary period has ended, whichever occurs first. This section shall apply **except** in any case in which the Board determines that compelling circumstances warrant the continued reimbursement during the probationary period of any Medi-Cal claim for services. In such a case, the department shall continue to reimburse the licensee for all procedures, except for those invasive or surgical procedures for which the licensee was placed on probation.

SUMMARY OF DISCIPLINARY CHARGES

5. The overall diagnosis and treatment by respondent of patient B.R. on five visits covering the seven months from April to October of 1993 represent an ~~extreme~~ departure from the standard of practice of medicine. Respondent failed to demonstrate the level of knowledge or skill required of a physician by failing to perform meaningful medical evaluations, failing to consider diagnostic differentials, and failing to prescribe correct therapies. With repeated negligence, respondent failed to order or to perform needed diagnostic tests on numerous occasions. In summary, respondent failed to evaluate and to treat the patient for abdominal pain, shortness of breath, and hypertension.

In an unrelated incident, respondent stole merchandise from Fry's Electronics, Anaheim, California, and was convicted therefor.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

6. Respondent Chander Prakash Sharma, M.D., is subject to disciplinary action on account of the following:

Visit of April 9, 1993

A. On or about April 9, 1993, B.R., a 32-year-old male, initially visited the medical office of respondent, The Advanced Family Medical Group, Anaheim, California. Respondent failed to document a "chief complaint." The patient filled in a standard form of history, in which, under the heading "PAST/PRESENT HISTORY: MAIN PROBLEMS" he indicated a history of sinus trouble, bronchitis, chronic cough, asthma, wheezing, chest pain, shortness of breath when lying flat, and smoking. The patient listed current medications as including Tussi-Organidin (a cough syrup), Proventil and Vanceril inhalers (for asthma), and Vancenase AQ (for allergic rhinitis).

B. During his contact with the patient on April 9, 1993, respondent neither elicited nor documented any further history.

C. During his contact with the patient on April 9, 1993, respondent did not inquire into, or make written comments on the items checked off by the patient in the "PAST/PRESENT HISTORY: MAIN PROBLEMS" list.

D. On or about April 9, 1993, respondent completed ~~a~~ check-off list of items under the heading "PHYSICAL EXAM." Blood pressure was documented as 158/110. All items in the list were marked as "Normal/Neg." by respondent, except for ears, nose/sinuses, pharynx, and neck glands.

E. Respondent made a single significant clinical finding of "bilateral ronchi of the lungs."

F. Under the heading "Clinical Impressions" in the standard form used by respondent, he wrote "Bronchial asthma, allergic rhinitis, acute pharyngitis - URI, hypertension."

G. Respondent's plan of therapy included prescribing Amoxil (an antibiotic), Proventil tablets, theophylline (for asthma), and Proventil and Vanceril inhalers. Respondent indicated in the medical record he was to follow the patient's blood pressure. The foregoing constitutes a summary of the complete medical record of the patient made by respondent on that date.

Visit of April 13, 1993

H. On or about April 13, 1993, patient B.R. returned to the office of respondent. On this occasion the patient's chief complaints were documented by front-office assistants of respondent as including abdominal pain, nausea, and shortness of breath. Respondent obtained no further medical history of the patient on this visit.

I. On this visit, the blood pressure of B.R. was 170/112, and other vital signs were normal. Respondent noted the patient to be alert, active, nontoxic, and afebrile; his oropharynx to be exudative, and his tympanic membranes to be clear. Respondent described the nasal turbinates of the patient to be hypertrophied, and found "occasional" cervical lymph nodes. The patient's breath sounds were noted to be "clear" and "occasional expiratory ronchi [sic]" were documented.

J. On the findings set forth in the preceding paragraph, respondent formed the clinical impression that the patient had bronchial asthma, dyspepsia, bronchitis, and hypertension. The treatment plan documented by respondent included prescriptions for Amoxil, theophylline, Proventil tablets, and Pepcid (for the "dyspepsia"). Respondent had the patient follow up in his office in one week to check his blood pressure and "to do work-up."

Visit of April 20, 1993

K. On or about April 20, 1993, patient B.R. returned to the office of respondent for his third visit. On this occasion the patient's chief complaints were documented by respondent's front-office assistants as including "severe asthma" and "sore throat." Respondent obtained no further history of the patient's present illness.

L. On this visit, the blood pressure of B.R. was 160/100 and other vital signs were normal. Respondent again noted the patient to be alert, active, nontoxic, and afebrile; his oropharynx to be exudative, and his tympanic membranes to be clear. Respondent's physical findings included hypertrophy of the nasal turbinates and occasional rales and ronchi of the lungs.

M. Respondent formed the clinical impression that the patient had "hypertension, laryngotracheobronchitis, bronchial asthma, [and] allergic rhinitis." The treatment plan documented by respondent included continuation of prescriptions for theophylline, Pepcid, and Proventil; and Cipro (an antibiotic). Respondent ordered an urinalysis and cardiac profile. Respondent indicated in chart notes that the diagnosis of hypertension was discussed, and he advised B.R. to see a cardiologist. Respondent had the patient follow up in his office in seven days to check blood pressure and "to do work-up."

N. A cardiac profile was obtained on or about April 21, 1993. Test results revealed a cholesterol of 317, a very high reading; an HDL cholesterol reading of 101, also high; a high triglyceride level; and a normal blood sugar.

O. The chart of the patient does not contain any indication an urinalysis was performed or documented.

Visit of May 3, 1993

P. On or about May 3, 1993, patient B.R. returned to the office of respondent for his fourth visit. On this occasion the patient's chief complaints were documented by respondent's front-office assistants as including "allergies, asthma and abdominal symptoms." Respondent wrote that the patient's "nausea [was] better" and the patient "denied any febrile illness."

Q. On this visit, the blood pressure of B.R. was 172/118. The remainder of the examination performed by respondent on that date was unremarkable except for continued hypertrophy of the nasal turbinates.

R. Respondent formed the clinical impression that the patient had "hyperlipidemia, hypertension, bronchial asthma, [and] allergic rhinitis." Respondent prescribed Maxzide (a diuretic), Isoptan (a blood pressure medication) and a low cholesterol diet. Respondent gave the patient a cardiology referral and ordered a follow-up visit in seven days.

Visit of October 20, 1993

S. On or about October 20 1993, patient B.R. returned to the office of respondent for his fifth visit. On this occasion the patient's chart is blank as to chief complaints.

T. On this visit, the blood pressure of B.R. was 180/120. The remainder of the examination performed by respondent on that date was unremarkable.

U. Respondent formed the clinical impression that the patient had "hypertension - uncontrolled; bronchial asthma." Respondent documented that patient B.R. had not been taking his medication for five months. Respondent prescribed Zocor (for cholesterol), Lotensin (for blood pressure), Calan (for blood pressure), Proventil and Vancenase inhalers, and theophylline. Respondent indicated in the patient's chart that the treatment, diagnosis, prognosis, follow-up therapy, and complications were "emphasized" with the patient. Respondent also documented that the patient had refused to see a cardiologist.

V. Patient B.R. made no further visits to respondent.

W. In November of 1993, patient B.R. developed renal failure and was subsequently placed on dialysis.

Medical Records of Patient B.R.

X. Medical records of the visits of patient B.R. to the office of respondent on April 9, April 13, April 20, May 3, and October 20, 1993, contain substantial portions that are illegible.

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Y. The illegibility of the medical records of April 9, April 13, April 20, May 3, and October 20, 1993, makes them uninterpretable by any subsequent reviewer or health care provider.

Z. In a "SUMMARY OF TREATMENT AND CIRCUMSTANCES OF THE CASE," prepared and submitted to the Board, respondent alludes to multiple discussions with patient B.R. which were not documented in the medical record.

7. Respondent Chander Prakash Sharma, M.D., is subject to disciplinary action under section 2234, subdivisions (a) and (b) of the Code in that he committed acts or omissions constituting gross negligence. The circumstances are as follows:

A. Complainant realleges all matters set forth herein above at Paragraph 6.

B. The overall diagnosis and treatment of patient B.R. by respondent during the five-month period encompassed by April 9, 1993, and continuing through and including October 20, 1993, constitute an extreme departure from the standard of practice of medicine in this State.

C. Respondent failed during the visit of April 13, 1993, to obtain a reasonable medical evaluation of the patient's complaint of abdominal pain and failed to formulate a differential diagnosis for such complaint.

D. Respondent repeatedly failed during the five-month period encompassed by April 9, 1993, and continuing through and including October 20, 1993, to obtain meaningful medical histories from patient B.R.

E. Respondent repeatedly failed during the five-month period encompassed by April 9, 1993, and continuing through and including October 20, 1993, to perform medically adequate physical examinations of patient B.R.

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F. Respondent failed during the visits of April 13, April 20, and May 3, 1993, to obtain a reasonable medical evaluation of the patient's complaint of shortness of breath and failed to consider a differential diagnosis for such complaint, despite the ineffectiveness of the treatment respondent had prescribed.

G. Respondent failed during the visits of April 9, April 13, April 20, May 3, and October 20, 1993,

(1) To perform any significant investigation of the patient's hypertension.

(2) To order indicated diagnostic tests which included blood chemistries (BUN and Cr to measure renal function) and EKG, and to obtain results for an urinalysis he ordered on one occasion.

(3) To examine the fundi, perform an EKG, and order/interpret an urinalysis, in order to assess the patient for end organ damage from the ongoing and severe hypertension.

(4) To prescribe appropriate therapies for hypertension, a common diagnosis among patients treated by general or family practitioners.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

8. Respondent Chander Prakash Sharma, M.D., is subject to disciplinary action under section 2234, subdivisions (a) and (c) of the Code in that he has committed repeated acts or omissions constituting negligence. The circumstances are as follows:

A. Complainant realleges all matters set forth herein above at Paragraphs 6 and 7.

B. Visit of April 9, 1993

(1) Respondent failed to obtain a "chief complaint" or a medically adequate "history of present illness."

(2) Respondent prescribed Proventil tablets in addition to

Proventil inhalation without medical indication for dual prescribing of the same drug.

(3) Respondent prescribed Proventil tablets in addition to Proventil inhalation for a patient with a marked elevation in blood pressure.

(4) Respondent prescribed theophylline without instituting a plan to check a serum drug level.

C. Visit of April 13, 1993

(1) Respondent failed to obtain an interval history for the diagnosis of asthma.

(2) Respondent failed to evaluate the complaint of abdominal pain, through his failure to obtain a precise medical history, failure to inquire into pain characteristics, failure to make physical findings after performing a medically adequate physical examination, and failure to discuss findings which would support his diagnosis of "dyspepsia."

D. Visit of April 20, 1993

(1) Respondent failed further to evaluate the patient's complaint of severe asthma, when the inefficacy of respondent's current treatment for that condition was or should have been apparent.

(2) Respondent failed to obtain diagnostic testing, including chest x-ray and pulmonary function tests, despite the continuing complaints by the patient of shortness of breath.

(3) Respondent failed to have medical justification supporting his diagnosis of laryngotracheobronchitis.

(4) Respondent failed to have medical justification supporting his prescribing of the antibiotic Cipro in the treatment of laryngotracheobronchitis.

(5) Respondent failed to document the results of the urinalysis

obtained on April 20, 1993, if in fact the urinalysis was completed.

E. Visit of May 3, 1993

(1) Respondent failed to evaluate for end organ damage after noting the markedly increased blood pressure of that date; specifically, respondent failed to conduct an ophthalmic examination of the fundi for exudate and hemorrhage, failed to order or evaluate an urinalysis, and failed to order or evaluate an EKG.

(2) Respondent failed to obtain an interval history regarding the asthma.

F. Visit of October 20, 1993

(1) Respondent failed to obtain an interval history or chief complaint.

(2) Respondent prescribed two new anti-hypertensive medications, Lotensin and Calan, to be taken simultaneously.

(3) Respondent prescribed Lotensin without first having a knowledge of baseline renal function and without follow-up of renal function.

(4) Respondent prescribed Zocor without first having a knowledge of baseline liver function and without follow-up of liver function.

G. All Visits

(1) Respondent illegibly documented his diagnosis and treatment of the patient.

(2) Respondent failed to record, and to comment upon, the result of the urinalysis he indicated he had ordered, or in the alternative, failed to follow up when the urinalysis was not performed.

(3) Respondent failed to document the many conversations respondent claims in his treatment summary to have had with the patient, or in the alternative, respondent had no such conversations.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

9. Respondent Chander Prakash Sharma, M.D., is subject to disciplinary action under section 2234, subdivisions (a) and (d) of the Code in that he has committed acts or omissions constituting incompetence. The circumstances are as follows:

A. Complainant realleges all matters set forth in Paragraphs 6, 7 and 8 herein above.

FOURTH CAUSE FOR DISCIPLINE

(Dishonesty or Corruption)

10. Respondent Chander Prakash Sharma, M.D., is subject to disciplinary action on account of the following:

A. On or about June 7, 1997, respondent entered Fry's Electronics store in Anaheim, California. Respondent selected a Weller brand thin soldering iron and a package of TV/radio solder from the electronics components department and carried them with him to the computer department. As respondent was walking down the center aisle of the store, he opened the packaging of the soldering iron. Respondent then concealed the soldering iron in the right front pocket of his trousers and concealed the solder package in the left front pocket of his trousers. Respondent passed by all the operating check-out registers and proceeded to the exit of the store without paying for the merchandise he had placed in his front pockets. When he was about 20 feet outside the store, respondent was apprehended by agents of the store.

11. Respondent Chander Prakash Sharma, M.D., is subject to disciplinary action under section 2234, subdivisions (a) and (e) of the Code in that he has committed an act of dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon. The circumstances are as follows:

A. Complainant realleges all matters set forth herein above at Paragraph 10.

B. Respondent committed theft of merchandise from Fry's Electronics store, an act of dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

FIFTH CAUSE FOR DISCIPLINE

(Conviction of Offense)

12. Respondent Chander Prakash Sharma, M.D., is subject to disciplinary action under section 2234, subdivision (a) and section 2236 of the Code in that he has been convicted of an offense which is substantially related to the qualifications, functions, or duties of a physician and surgeon. The circumstances are as follows:

A. Complainant realleges all matters set forth herein above at Paragraphs 10 and 11.

B. On or about June 18, 1997, In the Municipal Court, North Orange County Judicial District, County of Orange, State of California, Case No. AN97NM05632, in the matter entitled *The People of the State of California, Plaintiff, vs. Chander Prakash Sharma, Defendant*, respondent was charged with one count of committing a crime by violating sections 484-488 of the California Penal Code, a misdemeanor, by willfully and unlawfully stealing, taking and carrying away the personal property of another, to wit: Fry's Electronics, 3370 East La Palma Avenue, of a value of less than $400.

C. On or about November 17, 1997, in the aforementioned criminal proceeding, respondent pleaded guilty to the crime of violating section 602, subdivision (j) of the California Penal Code, a misdemeanor by committing a trespass, i.e., entering lands for the purpose of injuring any property or property rights or with the intention of interfering with, obstructing, or injuring any lawful business or occupation carried on by the owner of the land or by the person in lawful possession. In connection with his guilty plea, imposition of sentence of respondent was suspended, three years of informal probation were ordered, and terms and conditions were imposed which included paying

the Court $300 as a fine and penalty assessment, the State Restitution Fund $100, and the Court $10 for the crime prevention fund.

D. The circumstances of the conviction are as set forth herein above at Paragraph 10.

PRAYER

WHEREFORE, the complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Division issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number A 30135, heretofore issued to respondent Chander Prakash Sharma, M.D.;

2. Revoking, suspending or denying approval of respondent's authority to supervise physician's assistants, pursuant to section 3527 of the Code;

3. Ordering respondent to pay the Board the reasonable costs of the investigation and enforcement of this case and, if placed on probation, the costs of probation monitoring;

4. Taking such other and further action as the Division deems necessary and proper.

DATED: April 16, 1999.

Ron Joseph
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California

Complainant

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